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Original vs. actual results: Discussion continues

by Roland (Guy) King

Like the original Medicare estimates discussed by Robert J. Myers in *The Actuary* (February 1994), the cost of the End Stage Renal Disease (ESRD) program also is thought by many actuaries to have been seriously underestimated by government actuaries. The fact sheet accompanying this article discusses the original estimates for the ESRD program and compares them with actual results, showing that the original estimates were really very accurate.

The Chronic Renal Disease (as it was called in 1972) amendment was offered without warning on the Senate floor by Sen. Vance Hartke (D-Ind.), with his estimates prepared by advocates of the coverage. In response, David McKusick and Gordon Trapnell of the Social Security Administration prepared actuarial estimates, which they presented to Rep. Wilbur Mills (D-Ark.), then chairman of the House Ways and Means Committee.

I was an entry-level actuary when the ESRD program was enacted, so I saw the harsh criticism to which McKusick and Trapnell were subjected. Their estimates almost universally were criticized for being too high. They were pilloried in the trade press and accused of producing politically motivated estimates that would result in unnecessary deaths should the legislation not pass. Experience has shown

their projections, produced from scratch in less than three days, actually were very good. Now the projections are erroneously criticized for having been grossly underestimated, once again demonstrating that no good deed goes unpunished.

Myers' analysis of the projection error in the original Hospital Insurance (HI) estimates was based on costs expressed as a percentage of payroll, and I agree with him that it is appropriate to express the estimates for a program financed by payroll taxes as a percentage of payroll.

However, while accounting for certain liberalizations in the Medicare eligibility requirements, Myers' analysis doesn't account for all the legislative changes that reduced the cost of the HI program. Soon after the program began, legislation was enacted transferring all outpatient hospital diagnostic services to the Supplementary Medical Insurance (SMI) program (known as Part B of Medicare). Many other bills have been enacted since 1980 that reduce the HI outlays, including the Omnibus Budget Reconciliation Act of 1981, Tax Equity and Fiscal Responsibility Act of 1982, Social Security Amendments of 1983, Deficit Reduction Act of 1984, Consolidated Omnibus Budget Reconciliation Act of 1986, and the Omnibus Budget Reconciliation Acts of 1986, 1987,

and 1989. By 1990, the accumulated savings of these laws was more than 0.6% of taxable payroll, which represents a much greater savings than the cost of the expansions of the 1972 amendments.

Mary Adams, editor of the issue in which Myers' article appeared, included an editor's note: "...Who would have thought that Part A medical costs would increase at such a significantly higher rate than the rate of inflation reflected in wage increases?" Actually, hospital cost increases in excess of wage increases accelerated only modestly after 1965.

(continued on page 3)

Featured this issue:

Original vs. actual results	1
<i>by Guy King</i>	
Editorial: Health care reform and malpractice	2
<i>by Robert Dobson</i>	
Moscow diaries	4
A little known fact about health care	8
<i>by Daniel Wolak</i>	
Joint executive meeting	9
<i>by Jeff Furnish</i>	
Life in LA: Predicting the unpredictable	10
<i>by Song Song Shu</i>	
Letters to editor	15
Actucrostic	16

best by doing good work, which involves peer review and good documentation.

This may be my only column directly devoted to malpractice, but it will not be the last on the changes occurring in our health care system and related professional issues. Readers reactions are more than welcome; they are encouraged (dare I say mandated?).

Editor's note: We are pleased that an expert in the financing and delivery of health care, Bob Dobson, has joined the editorial board. He takes the place of Tony Spano, who served on the editorial board from 1990-93. Spano had filled several publication roles for the Society since 1973 and was director of publications in 1986 when The Actuary restructured with its present system of revolving

associate editors. We owe Tony our gratitude for his long, capable service.

Dobson is a consulting actuary with Milliman and Robertson's Atlanta office. In addition to being a frequent speaker at Society meetings, he is the immediate past president of the Conference of Consulting Actuaries and has been a vice president of the American Academy of Actuaries.

Original vs. actual (continued from page 1)

Hospital costs had been increasing much faster than wages for many years before 1965, and this fact was well-known at the time. H. Lewis Reitz, executive vice president of the Great Southern Life Insurance Company, testified against the forerunner of Medicare before the Senate Finance Committee on August 13, 1964. His testimony, complete with a comprehensive actuarial memorandum, stated, regarding the administration's estimate, "It relies upon the questionable assumption that hospitalization costs will increase after 1971 at the same rate

as any increase in earnings levels, whereas the increase in hospital costs has outstripped the increase in earnings levels through 1963. ...We concur with the opinion of most hospital authorities and medical economists, that hospital per diem costs will continue to rise faster than average wages for the foreseeable future." The actuarial memorandum (author unknown) had identified a key source of projection error in the original Medicare cost projections.

Those who are interested in a more detailed explanation of the difference between the administration estimates

and the insurance industry estimates can find an explanation in the *Transactions*. A memorandum documenting the difference in the estimates and signed jointly by Robert J. Myers (representing the administration) and D.W. Pettengill (representing the insurance industry) was inserted in the *Transactions* (Volume XVII, Part I, 1965; p. 534) by Gordon Trapnell.

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Fact sheet

Following is a comparison of actual results with the original estimates for Section 299I of the 1972 Social Security Amendments. Section 299I established eligibility for Medicare for persons suffering from End Stage Renal Disease (ESRD), then called Chronic Renal Disease (CRD). Both aged and disabled beneficiaries may receive ESRD services, but the 299I beneficiaries are those people who qualify for Medicare solely on the basis of having ESRD.

As the table shows, the original estimates were reasonable compared with the actuarial experience. Because the ESRD program has grown rapidly, observers often jump to the erroneous conclusion that the original cost estimates were grossly understated.

In addition, some uninformed observers have contributed to the confusion by inappropriately comparing all ESRD expenditures with the original estimates for the 299I group only. Persons who qualify for Medicare as aged or disabled beneficiaries also can receive ESRD services, but the costs of those services were already included in other cost estimates for the 1972 Amendments. For example, costs of ESRD services for the disabled population were not included in the 299I estimates, but instead were part of the cost estimates for extending Medicare coverage to the disabled population. The cost for the disabled population also was not underestimated.

Originally, long-range estimates beyond five years were only prepared for the Hospital Insurance (HI) program, and the estimates for the Supplementary Medical Insurance (SMI) program

did not extend beyond five years. For the comparison of the long-range estimates shown below, the SMI ESRD benefit estimates were extended beyond five years by assuming the same ratio of SMI to HI ESRD benefits as in the short range. Part of the reason for the lower comparison ratio in more recent years is the various cuts in provider payment levels caused by legislation in the 1980s. These cuts affected providers of ESRD services as well.

Short-range estimates:

<u>Fiscal Year</u>	<u>Orig. Est.</u>	<u>Actuals</u>	<u>Ratio*</u>
1974	\$ 98 M	\$ 99 M	1.01
1975	152	187	1.23
1976	190	236	1.24
1977	242	267	1.10

Long-range estimates:

<u>Fiscal Year</u>	<u>Orig. Est.</u>	<u>Actuals</u>	<u>Ratio*</u>
1980	\$ 481 M	\$ 488 M	1.01
1985	1293	1094	0.85
1990	2326	1861	0.80

* Ratio is the actual expenditures divided by the original expenditure estimates.